

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6015879	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 07/14/2016
NAME OF PROVIDER OR SUPPLIER MANOR COURT OF CLINTON		STREET ADDRESS, CITY, STATE, ZIP CODE 1 PARK LANE WEST CLINTON, IL 61727			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	<p>Final Observations</p> <p>Licensure Violations:</p> <p>300.1210b) 300.1210d)6) 300.3240a)</p> <p>Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.</p> <p>d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:</p> <p>6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.</p> <p>Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.</p> <p>These requirements are not met as evidenced by:</p>		S9999	<p>Attachment A Statement of Licensure Violations</p>	

Illinois Department of Public Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/29/16

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S9999	Continued From page 1 Based on interview and record review the facility failed to ensure R1 was safely transferred using a sit to stand with two staff member s to assist for one (R1) of three residents reviewed in the sample of three residents reviewed for transfers. The facility's failure resulted in R1 sustaining a subarachnoid hemorrhage. Findings include: R1's Physician Order Sheet (POS) dated July 2016 documents R1's diagnoses as Subarachnoid Hemorrhage, Muscle Weakness, Cognitive Communication Deficit, History of Falling, Cerebral Vascular Accident, Muscle Wasting and Atrophy, Syncope and Collapse, and Multiple Sclerosis. This same POS also documents a physician's order for an anticoagulant since R1's admission to the facility on 1/23/15. R1's Brief Interview for Mental Status (BIMS) dated 5/30/16 documents R1's score of 8 indicating R1 as cognitively moderately impaired. R1's pre-fall (6-17-16) Fall Risk Assessment dated 3/24/16 documents a score of 19 indicating R1 is a high fall risk. R1's Care Plan dated 5/25/16 documents R1's mobility as left-sided weakness and Multiple Sclerosis impacting R1's transfers. This same Care Plan also documents the requirement to use the stand aide (sit to stand) with the assistance of two members for transfers for R1. R1's Progress Notes dated 6/17/16 documents "(R1's) knees gave out while standing....and (R1) fell onto the floor on left side....immediate formation of a softball sized hematoma to left side of head." R1's Progress Notes dated 6/20/16 document R1 returned to the facility where R1 resides.	S9999			

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S9999	Continued From page 2 R1's Patient Summary dated 6/17/16 from R1's Emergency Room (ER) visit documents R1 arriving on 6/17/16 at 9:56 AM in critical condition, on an anticoagulant, in pain at left eyebrow area from a mechanical fall at the facility where R1 is staying. The Computed Tomography Report from the ER visit dated 6/17/16 for R1 documents the findings as evidence of a small area of Subarachnoid hemorrhage in the left occipital lobe due to a ground-level fall at the nursing home striking left forehead on concrete (initial encounter). R1's diagnosis from the ER report dated 6/17/16 documents R1 as having a Subarachnoid Hemorrhage following injury. The ER report dated 6/17/16 for R1 documents R1 arrived with threat for imminent organ system collapse secondary to fall with head injury, on anticoagulation...patient stabilized for transfer to local trauma facility. The Trauma Evaluation History and Physical dated 6/17/16 documents R1 as taking Plavix 75 milligrams (mg) everyday. This same report documents active hospital problem as a fall - on coumadin/plavix (blood thinning medication) and a subarachnoid hemorrhage with a plan to admit to trauma. This report also documents International Normalized Ratio (INR) reversed with Fresh Frozen Plasma (FFP) and Vitamin K. The brain scan without contrast dated 6/18/16 impression documents slight increased size of the probable Subarachnoid blood within a left parietal sulcus...there may be a tiny adjacent parenchymal hemorrhage. On 7/12/16 at 12:07 PM, E3, Certified Nurse Assistant (CNA) stated on 6/17/16 E3 was getting R1's weight and as getting resident back into wheelchair, R1 fell. E3 stated R1 requires the use of a sit to stand for all transfers and has been	S9999			

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S9999	Continued From page 3 for a while. E3 stated E3 weighed R1 by herself. E3 stated E3 should have been a two person transfer according to R1's 5/30/16 Care Plan. E3 also stated "I should have used the stand aid (sit to stand) and another CNA when weighing the resident (R1)...I made a bad judgement call". On 7/12/16 at 12:37 PM, E2 Director of Nursing (DON) stated on 6/17/16 E3 thought it was okay to weigh R1 with no assist but R1 is supposed to be "a stand aide (sit to stand) transfer with two assist." E2 also stated E3 transferred R1 incorrectly and E2 doesn't see how R1 could have fallen if the transfer was done correctly. On 7/13/16 at 3:30 PM E1 Administrator stated E3 was weighing R1 on 6/17/16 in the hallway and R1 sat down before E3 was able to get the wheelchair under R1. E1 stated E1 would expect E3 to follow R1's Care Plan and to use a stand aide, gait belt and two assist (with transfers). E1 stated E3 transferred R1 by E3's self. On 7/14/16 at 2:00 PM, Z1, Physician stated the Subarachnoid Hemorrhage was caused from the fall R1 had on 6/17/16 at 10:02 AM. This failure resulted in R1 falling and sustaining a Subarachnoid Hemorrhage. (A)	S9999			

IMPOSED PLAN OF CORRECTION

Facility Name: Manor Court of Clinton

Survey Date: July 14, 2016

Survey: IRI 6/17/2016/IL86809

Violation: A

Administrative Code:

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

This will be accomplished by:

- A. The facility shall conduct mandatory in-services for nursing staff regarding safe resident handling and transfer procedures that are consistent with a resident's care plan.
- B. Under the supervision of the Director of Nursing or designee a plan will be implemented to monitor safe resident handling procedures consistent with a resident's care plan. Deficiencies that neglect residents care plan are to be corrected immediately and findings documented.

Completion date: Ten days from receipt of the Notice for the Imposed Plan of Correction

8/12/2016/JP

Attachment B
Imposed Plan of Correction

IMPOSED PLAN OF CORRECTION

Facility Name: Manor Court of Clinton

Survey Date: July 14, 2016

Survey: IRI 6/17/2016/IL86809

Violation: A

Administrative Code:

Section 300.1210 General Requirements for Nursing and Personal Care

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Section 300.3240 Abuse and Neglect

a) *An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident*

This will be accomplished by:

- A. The facility shall conduct mandatory in-services for nursing staff regarding safe resident handling and transfer procedures that are consistent with a resident's care plan.
- B. Under the supervision of the Director of Nursing or designee a Quality Assurance Improvement Plan will be implemented to monitor safe resident handling procedures consistent with a resident's care plan. Deficiencies are to be corrected immediately and findings documented.

Completion date: Ten days from receipt of the Notice for the Imposed Plan of Correction

8/12/2016/JP